ODA PRIMARY HEALTH CARE NETWORK
74 WALLABOUT STREET BROOKLYN, NY 11249
T: (718) 260-4600 - F: (718) 797-9075

NEW PATIENT REGISTRATION FORM

(Please print clearly and complete each application section)

Family Account #			PATIENT INFORMATION		PCP:
Gender: ☐ Male ☐ Female ☐ Other	Prefix: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Last Name:	Middle Name:	
			First Name:	Maiden Name:	
Is this your legal name? ☐ Yes ☐ No	If **NO**, what is your legal name?		Father's Name:	Mother's Name:	
Street Address:		Apt #/P.O. Box:	City:	State:	Zip Code:
Home Phone:		Cell Phone:	Email:		Legal Birth Date: / /
Pharmacy:	Race: (Please choose one) ☐ White ☐ Black/African American ☐ Asian ☐ Pacific Islander ☐ Native American/Alaskan Eskimo ☐ Other:		Ethnicity: (Please choose one) ☐ Hispanic ☐ Non-Hispanic		How did you hear about ODA? ☐ Family/Friend ☐ Doctor Hospital ☐ Insurance Plan ☐ Close to home/work ☐ Other:
Preferred Language: ☐ English ☐ Spanish ☐ Yiddish ☐ Other:			Sexual Orientation: ☐ Homeless ☐ U.S. Military Veteran		

INSURANCE INFORMATION - *Please give your insurance card to the registrar*

Is this person covered by insurance? ☐ Yes ☐ No	If **NO** please check self-pay below and the front desk will discuss with you our payment options based on your income level*	
Person responsible for bill:	Relationship to patient:	Is this person a patient here? ☐ Yes ☐ No
Address & Phone number (If different from above):		Birth Date: / /

Please indicate primary insurance: ☐ Self Pay* ☐ Medicaid ☐ Medicare ☐ HDA ☐ Other	Medicaid Managed Care: ☐ Health First ☐ HIP ☐ HealthPlus ☐ Fidelis ☐ United Health Care ☐ Other	Dental Only: ☐ HealthPlex ☐ Doral ☐ UHC Dental ☐ Other:	Patients relationship to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other:
Name of secondary/tertiary insurance (If Applicable):	Primary Policy#:	Secondary Policy#:	Tertiary Policy#:

EMERGENCY CONTACT

Name of the person that ODA should contact in the case of an emergency:		
Relationship to the patient:	Home Phone:	Cell/Work Phone:

The above information is accurate to the best of my knowledge. I authorize my insurance benefits to be paid directly to the ODA Primary Health Care Center. I understand that I am financially responsible for any balance. I also authorize ODA Primary Health Care Center or insurance company to release any information required to process my claims. I understand that to the extent I require services from any third party, such as a laboratory, I (and not ODA) will be responsible for any charges not covered by my insurance.

I also hereby authorize ODA Primary Health Care Center providers to perform ROUTINE EXAMS, TESTS, IMMUNIZATIONS and TREATMENT for the above named patient

Signature of patient/guardian:	Relationship to the patient:	Date: *(English)* / /

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Notice of Privacy Practices Acknowledgment

I hereby acknowledge reciept of the Notice of Privacy Practice

_____
Print Name

_____
Signature Date

I agree to have phone messages left to me on the phone numbers I provided as well as have letters sent to my address regarding appointments and test results.

PLEASE NOTE:
HIPAA regulations forbid ODA from sharing your health informatiom with any person with out the written permission of the patient or legal guardian.

If you want to allow ODA to give health information (i.e., referrels, immunization records, lab results, test results) to anyone besides the patient, you must fill out one of our PTD forms and include the names of the individuals that we may share your information with. This includes family members or schools.

Permission to Discuss

ODA wants to make sure your health information is not being given out incorrectly. If you have someone who may be calling ODA about your medical care, this form gives permission for ODA to share your information with these specific individuals. You can also use this form to authorize ODA to discuss your child's care with specific individuals.

Please note:

1. This form gives permission for ODA to discuss your care with a friend or family member. This form is not an authorization to release medical records.
2. Filling out this form does not stop ODA from other types of disclosures. ODA can still leave appointment reminder messages on your home phone or let someone pick up a prescription for you. For more information, please see ODA's Notice of Privacy Practices or call ODA's HIPAA Officer at 718-260-4600 x 354.

ODA may discuss my protected health information related to...

__ Pregnancy

__ routine test results

__My entire medical history

__ Other _____

...with the following person(s)

Name/Relationship/Address/Phone #: _____

Name/Relationship/Address/Phone #: _____

Name/Relationship/Address/Phone #: _____

Name/Relationship/Address/Phone #: _____

Name/Relationship/Address/Phone #: _____

Name/Relationship/Address/Phone #: _____

Name/Relationship/Address/Phone #: _____

This authorization is valid...

__ for five years

__ until ODA receives other written notification

__other_____

Patient's name: _____ Date of Birth: _____

Patient's signature: _____

Name, Relationship, and Signature
of Personal Representative (when applicable) _____

Date: _____

New York State Department of Health

Authorization for Access to Patient Information through a Health Information Exchange Organization

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow ODA Primary Health Care Network, Inc. to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Healthix's website at www.healthix.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for ODA Primary Health Care Network, Inc. to access ALL of my electronic health information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for ODA Primary Health Care Network, Inc. to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through Healthix and the consent process:

1. **How Your Information May be Used.** Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included.** If you give consent, the Provider Organization listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases

3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by Healthix's website at www.healthix.org or by calling 877-695-4749.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access.** Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call ODA Primary Health Care Network, Inc. at: 718-260-4600; or visit Healthix's website: www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/.*

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form.** You are entitled to get a copy of this Consent Form.